Title: Planning for systems-change: HIV/AIDS and Maternal and Child Health Program integration in the District of Columbia (2000-2004)

Health department/organization: District of Columbia DOH-HIV/AIDS Administration

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Goals: Integration of HIV prevention services into maternal and child health services

Program type: Community outreach; prevention case management

Collaborators: HIV/AIDS surveillance; MCH partners; CDC-funded national capacity-building providers

Background/Objectives

Federal and local sources provide funding to the Department of Health (DOH) and community-based organizations (CBOs) in the District of Columbia (DC). Multiple funding streams (Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and local funds) allow funds to be allocated for programs that target pregnant women and women at increased risk for HIV. Previously organizations in the DC area suffered from disjointed planning and fragmented services. Examples of specific problems: (1) No program allowed for all elements in the perinatal transmission continuum to be fully addressed. (2) There was inadequate coordination of these activities between DOH agencies and between CBOs. (3) HIV-positive pregnant women/ adolescents were not adequately linked to HIV specialty care and support services after being identified through outreach activities targeting pregnant women. (4) Data were not adequately shared between agencies and programs. (5) Training (clinical and non-clinical providers) on perinatal HIV was not coordinated across programs and DOH agencies.

From 1999-2004, the District of Columbia, Perinatal HIV Prevention Project sought to address these challenges by increasing the capacity of a maternal and child health program to make available HIV prevention services for their clients, and make referrals to individual prevention interventions delivered by a community HIV prevention partner. Specific objectives were: (1) to increase the number of Maternal and Child Health program (MCH) clients receiving HIV risk assessments and referrals to HIV prevention specialists co-located in the MCH program; (2) to establish an HIV prevention service "continuum" within the MCH program, by aligning HIV prevention activities with MCH activities, and (3) to increase the capacity of personnel at core MCH programs to appropriately deliver HIV prevention messages, risk assessments, and referrals.

Methods

Three tiers of activities were implemented: (1) the development of strategic planning and implementation teams within DOH and with community partners, (2) cross-program and agency training for clinical and non-clinical providers linked to HIV/AIDS and maternal and child health programs, and (3) co-location of various HIV health education/risk reduction (HE/RR) activities within DC Healthy Start, an outreach and case management program administered by the Maternal and Family Health Administration.

The initial planning phase of the project involved using tools to first identify systemic barriers linked to events impacting or interrupting identification of high-risk women and linkages to HIV prevention services. The planning teams also identified opportunities for systemic and programmatic impact, and implemented plans and policy recommendations. The framework was developed out of team participation in an urban learning cluster project created by CityMatCH, a national capacity-building provider.

The program component of the Perinatal HIV Prevention Project was defined by a partnership with the DC HIV/AIDS Administration (HAA) and MCH components of DOH, and a perinatal HIV prevention sub-grantee Children's National Medical Center—the lead agency for the Family Connections program. Family Connections is a network of Ryan White Title IV providers, including Howard University, DC General Hospital (Phoenix Center), Children's National Medical Center and Washington Hospital Center. The project placed a social work prevention case manager (PCM) and 3 outreach advocates within the DC Healthy Start Program, and from 2002-2003, an HIV counselor at a community health center (Mary's Center for Maternal and Child Health). The Perinatal HIV Prevention Project aligned HIV prevention outreach activities with MCH outreach, increasing the number of MCH clients receiving risk assessments and referrals to HIV health education/risk reduction services and HIV counseling and testing. Additional capacity-building resources supported cross-program and interagency planning for policy development, systems integration and evaluation.

Results

By 2004, this program model increased the capacity of MCH to make direct and appropriate referrals to co-located HIV prevention interventions for pregnant and high-risk heterosexual women.

A total of 4,377 high-risk women were reached through MCH programs with outreach and referral services (3,255 women), individual prevention counseling (967 women) and prevention case management (155 women) from 2000-2004. There were 1,108 referrals to HIV testing in conjunction with outreach and individual-level interventions, but systems were not in place to support adequate tracking of referrals to determine whether and where clients obtained testing and results through this mechanism.

Women and service providers were also reached with several Health Communication/Public Information (HC/PI) activities, including a media campaign (1,924 print and transit ad placements), distribution of perinatal HIV prevention brochures and provider information kits (13,352), small-group informational sessions/presentations (1,326) and outreach at community events and health fairs (6,746).

A DOH internal Perinatal HIV Prevention team was initiated, along with a Perinatal HIV Stakeholder Committee, and clinical advisory group. The DOH team was sustained while the other groups were convened intermittently to support specific activities, including development of provider training modules and revision of District perinatal HIV testing standards documents.

Conclusions

The program met the objective of co-locating HIV prevention services within an MCH program and effectively aligning outreach, educational, and counseling services with similar activities delivered by MCH. However, more capacity-building activities need to be done in order to ensure (1) sustainability—especially during the next 3 years, when priority

DOH perinatal HIV prevention efforts will focus on clinical provider standards and training for prenatal HIV testing, (2) increased capacity of MCH to deliver its own HIV prevention services, and (3) development of effective mechanisms to monitor referrals and referral tracking from MCH to HIV services delivered by DOH and community-based providers. The range of activities and number of client targets reached from the years 2000-2004 demonstrate the MCH's capacity to respond to co-location strategies. The next phase of the project will provide a comprehensive capacity needs assessment to determine the extent to which the Maternal and Family Health Administration can provide and manage HIV prevention services delivered by MCH staff.

The program was not adequately structured to effectively identify HIV-positive pregnant women, but 7 HIV-positive pregnant women were provided prevention case management in 2003-2004. They were appropriately linked to an HIV specialty care provider (Ryan White Title IV), where case management, support, and care were delivered. Protocols for developing better case studies in this context will be developed in the next phase of the project to determine the source of referrals and to track client services and outcomes for any HIV-positive pregnant woman reached.

The series of media, community awareness/ education, and provider training activities resulted in increased responsiveness of community partners, providers, and sister DOH agencies and facilitated their participation in planning and advisory activities. There was no direct link between the increase in HC/PI activities and increased capacity to reach clients or provide activities via MCH.